Medi-Cal Management Information
System and Decision Support System (MIS/DSS)

Data Enhancement Functional Specifications

for Medical Service Tables

Phase 5

March 23, 2000

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1. Overview

This document describes the Medical Claims Convert program (hereafter referred to as the "Claims Convert"), which creates the input files that become the DataScan Core Inpatient Service and Outpatient Service tables (Medical Service Tables). The Medical Service Tables contain data on inpatient and outpatient utilization.

The input for the Claims Convert program is the non-Drug file output by the Splitter program (see Section 2, Prerequisites/Pre-Conversion, and Attachment 1, Input Data Layout).

In addition to the file created for the Medical Service Tables, the Claims Convert program produces the Failed Operations Log (FOLOG) Report and an Aggregate Statistics Report. The Failed Operations Log (FOLOG) Report documents record counts (usually failures) in converting data into the standard values defined in the convert specifications. The Aggregate Statistics Report displays information on the records dropped during the convert process.

Figure 1 gives a high-level view of the major conversion processes and helps illustrate the relationship between the processes. The shaded box represents the conversion process being discussed in this section.

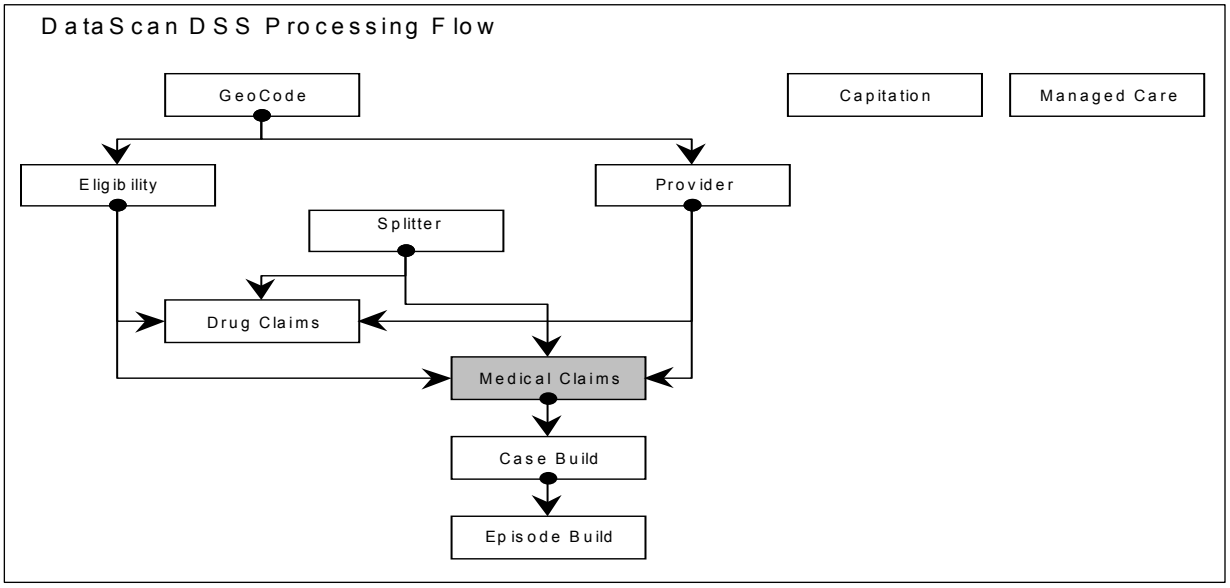

Figure 1. DataScan DSS Processing Flow

2. Prerequisites / Pre-Conversion

There are two prerequisites to the Claims Convert program. First, the Splitter Program must be run prior to the Claims Convert Program. The Splitter Program is designed to reformat the claims into a service-line detail level. The Splitter program breaks out the detail service lines as separate records and includes the header information on each record. The Splitter Logic is described in detail in the *Data Enhancement Functional Specifications for the Splitter Program,* provided in this System Design under separate tabs.

Second, The Eligibility Table and Provider Background Table must be created prior to the Claims Convert, because the Claims Convert programs use information from these external tables. Please see *Data Enhancement Functional Specifications for Provider Background/Directory,* and *Data Enhancement Functional Specifications for Eligibility, Populations, and DHS Core*, for a detailed description of the provider and eligibility conversion processes. These documents are provided in this System Design under separate tabs.

3. Indexes

The indexes for the Medical Service Tables are as follows:

- **Clustering**

  PRODUCT, NETWORK, ELIGCNTY, EMPID

- Secondary 1

  EMPID, MEMBERNO, PLACE (Outpatient Tables Only)

- **Secondary 2**

  DTROWUPD, CASEID (Inpatient Table Only)

- Secondary 3

  PGMCODE, PROC1, PROVCNTY

- Secondary 4

  SVCDTYY, SVCDTMM, PHPCODE

- **Secondary 5**

  ELIGCAT, VENDORCD

- **Secondary 6**

  EPIID (Outpatient Tables Only)

4. Input Data

The input data for the Claims Convert program includes the output claim detail files from the Splitter program, the converted Provider Table and the converted Eligibility Table.

For processing efficiencies, the output from the Splitter program is further segmented into several files. These segmented claim detail files are input to the Claim convert program. The Splitter program outputs fixed-length rather than variable-length records, one per input file segment.

Note: There are several reasons for having multiple input files. By running with multiple smaller files, multiple versions of the convert program can be executed simultaneously. This allows many records to be converted in parallel, rather than waiting for one long file to be processed one record at a time. Running the convert program in parallel with multiple smaller files allows the convert process to complete more quickly, allowing the scheduling of resources during a database installation to be scheduled more effectively. The use of multiple files also reduces recovery time if there is a problem and a file must be reconverted.

The number of output files used is determined indirectly by a JCL control card, which specifies the number of output records per file. For example, if the control card specifies 5,000,000 records per Claim file, and the Splitter outputs 82,000,000 records, each of the first 16 files will have 5,000,000 records each, the 17th will have 2,000,000, and the last three will have none. If the Splitter outputs 110,000,000 records, the first 19 files will have 5,000,000 records each, and the last will have 15,000,000 (all the rest).

The layout for the input files to the Claims Convert is the same as the F35-Input File, with these exceptions:

- Each record has only one segment, so the records are fixed- rather than variable-length. This entails changing the file layout by deleting the lines in bold type in Attachment 1.
- F35-SEGMENT-COUNT contains the actual segment number rather than the total number of segments on the input record. For example, if an input record has five detail segments, there will be five output records. The first will have F35-SEGMENT-COUNT = 1, the second 2, and so on. This field is used later for the Claim and Drug tables' LINENUM field.

The complete input file layout is included in Attachment 1.

5. Output Data

The output of the Claims Convert program is a flat file of converted claims. The Converted Claims file(s), after they are concatenated, serve as input to the DataScan Core Edit/Build processes. When the Edit/Build program is complete, the Medical Service tables discussed below become DB2 tables available within the DataScan application. Each of these Medical Service tables contains the same fields (or DB2 columns). The fields are described in detail in the Field Level Detail specification included in Attachment 3.

The DataScan Core Edit/Build processes produce the seven DB2 tables (called the Medical Service Tables), listed below, as well as the IP_CASE table. The IP_CASE table is discussed in *Data Enhancement Functional Specifications for Inpatient Case,* provided in this System Design under a separate tab.

5.1 IP_CLAIM

This table contains the medical services that are reported in the Case Table. The Case process is defined in more detail in the *Data Enhancement Functional Specifications for Inpatient Case*.

5.2 IP_CLM_PD

This table contains inpatient services that are no longer associated with a case, but are retained on the database because their paid dates fall within the 30-month window.

5.3 OP_CLAIM1 thru OP_CLAIM4

Up to four tables may be created that will contain all records that are not part of a case and have service dates that fall within the database 30-month window. Currently, only one table is "populated" with data – OP_CLAIM1.

5.4 OP_CLM_PD

This table contains outpatient services that service dates outside the 30-month window which have paid dates within the 30-month window.

6. Reports

The Claims Convert Program produces three reports: the Aggregate Statistics Report, the Failed Operations Log (FOLOG) Report, and the Unexpected Values Report. The DataScan CORE Edit program will produce two reports: the Edit Report and the Source of Payments Report. Samples of each of these reports are found in Attachment 2.

6.1 Aggregate Statistics Report

The Aggregate Statistics Report documents all records that drop because of incomplete information or the field value did not fall within a pre-defined range.

The Aggregate Statistics report will include:

- Total number of records processed
- Totals for key financial fields

6.2 Failed Operations Log (FOLOG) Report

The FOLOG Report documents records that have not been dropped but fail while converting raw input data into the format required for DataScan. The failure may be caused by one or more input fields that were not in the expected format (e.g., invalid data or non-numeric data in a numeric field). Please note that the FOLOG sometimes includes informational counts in addition to "failed" operations. For example, there is a FOLOG call to count the number of managed care encounters converted.

The FOLOG Report includes:

- Field name
- Operation Number
- Description of the operation that failed
- Unmapped/undefined values found for that operation
- Count of the number of records with possible errors for that operation
- Percent of Total Records

- NETPAY amount associated with each failed value
- Percent of total NETPAY associated with each failed value

The types of problems that the FOLOG report can highlight are:

- Wrong input file was converted.
- Wrong conversion program was run against the input file.
- Input file format changed.
- Unmapped fields or field values were in the input data.
- Incoming input data values were all blanks or zeros.
- Unexpected field values were present in the input data.
- Improper records were dropped.

NOTE: Refer to the Field Level Detail for more specific information on the FOLOG calls for individual fields reported on the FOLOG Report.

6.3 Unexpected Values Report

The Unexpected Values Report is very similar to the FOLOG Report with several additions and will:

- Indicate when a failed value has been confirmed by the State as an invalid value.
- List the unmapped/undefined values found for each operation by PHPCODE.

The fields on the Unexpected Values Report are a subset of the FOLOG Report and are driven by two Excel spreadsheets. The first spreadsheet is a list of FOLOG operation numbers to be included in the report. The second is a list of previously approved values to map to other/invalid for each operation number. The State should help determine which fields (only those listed in the FOLOG Report) to include in the Unexpected Values Report, as they will review these reports and provide any map updates before the next build or update.

6.4 The Edit Report

The Edit report, produced by the DataScan Core Edit program, provides information that can be used to validate the reasonability of the data. The Edit report provides the following information for selected fields

- Field Name
- Field Description
- Number of entries
- Percentage of missing data

6.5 The Source of Payment Report

The Source of Payment (SOP) report summarizes financial information for each of the months in the database.

7. Selection / Drop Criteria

All drop criteria are executed within the Splitter Program, so no drops are made specifically in the Claims Convert.

8. Process Flow / Data Enhancements

8.1 Financial Fields

Financial fields do not carry pennies, so rounding will occur during the data conversion process. All input fields will stay in the original un-rounded condition before and after all calculations have been completed. After the calculations are performed the result is rounded prior to being moved to the output fields. Also note, all input data to the convert will carry a plus or a minus sign.

The majority of the DataScan financial fields will use service line data elements, however, for certain financial fields only the claim header-level data elements are available. On the RF-O-35, the claim header-level amounts are stored in separate input fields from the service line amounts and are repeated on each line of the claim.

These claim header-level amounts will be assigned on the first service line (identified on the database as LINENUM=1) and all other services within that claim will be set to $0 for that particular financial field. Service line fields will be filled on all records within a claim.

Figure 2 below identifies which financial fields on the Medical Service Tables are created from claim header-level amounts and which are created from service line amounts:

Database Field	Header-Level	Service Line
CHG		X
COB	X	X
COPAY		X
DEDUCT	X	
HDRPAID	**X**	
NETPAY		X
PAY		X
SUBCHG		X
OHCAMT	X	
RPTNETMC		X

Figure 2. Financial Fields and Service Line Relationships

8.2 Mother/Baby Processing

The situation will arise in the Medi-Cal data where a claim for a baby uses the mother's unique beneficiary identification because the baby does not yet have it's own identification. Special logic will be used to identify these situations and a data element will be used to indicate when this has occurred.

The identification process is described here:

- If the age on the claim is 0 years old, the birth date on the claim will be compared to the birth date on the matching eligibility record. If these dates are more than 60 days apart, then it is assumed that the claim is for a newborn who is using it's mother's ID. The NEWBORN indicator is then set to 'Y'.
- Additionally, when NEWBORN gets set to 'Y', the field MEMBERNO will also get set to 1. This is done in order to distinguish these babies so that Inpatient Case build can recognize them as such. This way, the newborn's services will not be included in the mothers Inpatient Case record.

8.3 TAPEDATE Field Conversion

This date will be created during the convert process to identify each paid month of data submission. The TAPEDT will be passed to the convert program through an input control card located in the run JCL.

9. New Installation Considerations

During each of five implementation phases of the MIS/DSS project implementation, the DataScan database will be built with the data meeting the criteria of the current 30-month window. The Splitter Convert program validates the date criteria from the F35-File before including the claim in the output claim detail file(s). Therefore, during an installation, the Claim Convert program and ultimately the Claim tables will have only data that is within the Paid Date range for the 30-month window.

10. Update Processing Considerations

Update processing allows the 30-month window created during an installation process to be updated with more current data. The Update processes accepts one new month of claims data and rolls off the oldest month, maintaining only 30-months of Paid Claim data in the database at the conclusion of processing.

There is complex logic involved in the Case and Episode processes that are affected by the update process. When a new month of services are added to the database and when the oldest month must be rolled off, the Case and Episode processes also evaluate the services for inclusion or deconstruction of Cases and Episodes. More details about these processes can be found in the *Data Enhancement Functional Specifications for Inpatient Case* and *Data Enhancement Functional Specifications for Episodes,* provided in this System Design under separate tabs.

11. Maps and Validation Tables

Maps are used to validate source values before moving them to output, or to look up values for the output based on source values. Each map is sorted by the source values before the convert program is run. It is recommended that a map be sorted each time it is updated. Maps used by the Claims Convert are identified in Figure 3 below, and detailed in the Appendix to the System Design, *Reference Maps*.

Map	DataScan Field(s)	Excel Filename	Type of Mapping
AMBPROC	AMBPROC	AMBPROC.xls	Used to assign an ambulatory surgical grouping code based on the PROC1
DCHGBLNK	DSTATUS	DCHGBLNK.xls	Used to assign the MEDSTAT Discharge Status value from Patient-Status or Discharge-Code
DCHGDDS	DSTATUS	DCHGDDS.xls	"
DCHGDHS	DSTATUS	DCHGDHS.xls	"
DCHGLTC	DSTATUS	DCHGLTC.xls	"
DCHGU	DSTATUS	DCHGU.xls	"
DNTLORIG	DNTLORIG	DNTLORIG.xls	Used to assign the 3-digit Denti-Cal code using the HCPCS from the claim.
ELIGCAT	AIDCODE ELIGCAT	ELIGCAT.xls	Used to validate the AIDCODE being converted and to assign the appropriate ELIGCAT value based on the AIDCODE

Map	DataScan Field(s)	Excel Filename	Type of Mapping
FLGKEYCL	N/A	FLGKEYCL.xls	Used by the Unexpected Values Report – FOLOG operation numbers to be included in report
FLGAPRCL	N/A	FLGAPRCL.xls	Used by the Unexpected Values Report – values approved to map to other/invalid
HFPANUM	HFPANUM	HFPA.xls	Used to assign a HFPANUM from the converted PROVZIP
MCALAGE	MCALAGE	MCALAGE.xls	Used to map the AGE of the eligible to Medi-Cal defined Age Groups
NETPROD	PHPCODE	NETPROD.xls	Used to validate that a defined PHPCODE is being converted.
PLACACOM	PLACE	PLACACOM.xls	Used to assign the MEDSTAT Place-of-Service value from MIO-POS and ORIG-POS
PLACEDHS	PLACE	PLACEDHS.xls	“
PLACHCFA	PLACE	PLACHCFA.xls	“
PROVSPEC	PROVSPEC	PROVSPEC.xls	Used to validate that a defined Provider-Specialty value is being converted
PRTYP	PROVTYP	PRTYP.xls	Used to assign the MEDSTAT Provider Type value from Provider-Vendor-Code

Map	DataScan Field(s)	Excel Filename	Type of Mapping
PRTYP22	PROVTYP	PRTYP22.xls	Used to assign the MEDSTAT Provider Type value from Provider-Specialty and Vendor-Code
RVUADJ	RVUADJ	RVUADJ.xls	Used to calculate the Adjusted RVU amount
RVUHCFA	RVUTOT RVUWORK	RVUHCFA.xls	Used to identify Work RVUs to be used in the calculation of RVUTOT
RVUMODX	RVUTOT RVUWORK	RVUMODX.xls	Used to identify services based on PROCMOD that should excluded from the RVU assignment logic
RVUPLACE	RVUTOT RVUWORK	RVUPLACE.xls	Used to identify facility PLACEs that are subject to the HCFA site-differential when assigning RVUs.
RVUSURGX	RVUTOT RVUWORK	RVUSURGX.xls	Used to identify Surgical Services that should be excluded from the RVU assignment process.
SVCUB92	SVCTYP	SVCUB92.xls	Used to assign the MEDSTAT Service Type value using the UB92 field.
SVCST	SVCTYP	SVCST.xls	Used to assign the MEDSTAT Service Type for DDS services.
SVCLTC	SVCTYP	SVCLTC.xls	Used to assign the MEDSTAT Service Type for LTC services.

Map	DataScan Field(s)	Excel Filename	Type of Mapping
SVCMODE	SVCTYP	SVCMODE.xls	Used to assign the MEDSTAT Service Type Short-Doyle Inpatient services.
SVCCPT	SVCTYP	SVCCPT.xls	Used to assign the MEDSTAT Service Type for CPT / HCPCS / Local codes – when PROC1 is 5-bytes.
SVCCPT4	SVCTYP	SVCCPT4.xls	Used to assign the MEDSTAT Service Type for CPT / HCPCS / Local codes, when PROC1 is only 4-bytes.
SVCLAWAV	SVCTYP	SVCLAWAV.xls	Used to assign the MEDSTAT Service Type value from an LA Waiver Code
VENDORCD	VENDORCD	VENDORCD.xls	Used to validate that a defined Vendor-Code value is being converted

Figure 3. Maps used by the Claim Convert

12. Tagging

Some data elements are not available on the input file and need to be 'tagged' from other sources. Also, to enhance the analytic value of the MIS/DSS, we tag the Eligibility values to the Claim, for fields that are common between the Eligibility Table and the Claim, (regardless of the value submitted on the F35-File Claim record, with the exception of claims for NEWBORN services where we handle the fields BIRTHDT and SEX differently, see details below). The details for tagging are described below:

The fields that need to be tagged are described in Figure 4 below.

Field	File / Table	Tag Rules
BIRTHDT	Eligibility Table	If the Claim is not for a NEWBORN, tag from Eligibility, or set to missing if no Elig Match is found. Use the F35-Birth-Date if it is a NEWBORN claim.
CASENUM	Eligibility Table	Tag from Eligibility, or set to missing if no Elig Match is found; the Eligibility is more analytically valuable than the claim record.
DENTAL	Eligibility Table	Tag from Eligibility, or set to missing if no Elig Match is found; the Eligibility is more analytically valuable than the claim record.
ELIGSTAT	Eligibility Table	Tag from Eligibility, or set to missing if no Elig Match is found; this field is not available on the claim record.
ETHNCTY	Eligibility Table	Tag from Eligibility, or set to missing if no Elig Match is found; the Eligibility is more analytically valuable than the claim record.
EMPZIP	Eligibility Table	Present only on the Eligibility record.
LANGUAGE	Eligibility Table	Present only on the Eligibility record.
LATCODE	Provider File	Derived from Billing Provider Information.
LONGCODE	Provider File	Derived from Billing Provider Information.
MEDPHP	Eligibility Table	This is the Medical PHPCODE found in the Eligibility Table, it is tagged from Eligibility, or set to missing if no Elig Match is found.
NETWORK	Eligibility Table	Tag from Eligibility, or set to missing if no Elig Match is found; the Eligibility is more analytically valuable than the claim record.
NEWBORN	Eligibility Table	NEWBORN is determined when the f35-Birth-Date is more than 60 days different from the matching Eligibility BIRTHDT. When NEWBORN is ‘yes’, BIRTHDT and SEX are set to equal the f35 values.
PRODUCT	Eligibility Table	Tag from Eligibility, or set to missing if no Elig Match is found; the Eligibility is more analytically valuable than

Field	File / Table	Tag Rules
		the claim record.
PROVZIPB	Provider File	Present only on the Provider Background table.
PROVID	Provider File	Tagged from the Provider Background table in order to allow aggregation of medical services by provider.
RESCNTY	Eligibility Table	This is the County of Residence for the eligible and is only available on the Eligibility Table. Tag from Eligibility, or set to missing if no Elig Match is found.
SEX	Eligibility Table	If the Claim is not for a NEWBORN, tag from Eligibility, or set to missing if no Elig Match is found. If the Claim is for a NEWBORN, the birthdate on the claim reflects the child's date of birth. Therefore, set SEX = F35-BIRTH-DATE.
SSNMEDS	Eligibility Table	Tag from Eligibility, or set to missing if no Elig Match is found; the Eligibility is more analytically valuable than the claim record.

Figure 4. Fields Tagged in the Claim Convert

An input record will be tagged only once to each table and all relevant information that is needed, i.e. all fields that need to be obtained through tagging, will be retrieved during that tag.

12.1 Eligibility Tagging

Tagging to the Eligibility Table will always be keyed first to a match on F35-CIN and the month and year of service (SVCDTMM and SVCDTYY) from the claim to the EMPID and enrollment date (ENROLLDT), which is in CCYYMMDD format, found on the Partitioned Eligibility Table. These records must also contain an APPLIND of 'Y' or 'N'. When a match is found, the field RELMO is identified from the Partitioned Eligibility Table and used with the EMPID and ENROLLDT to get to the correct record on the Eligibility Table. (Note: The Partitioned Eligibility Table is used to maximize the efficiency of access to the Eligibility Table. The Partitioned Eligibility Table is a table of 34 months partitioned by relative month, RELMO. This table represents the database 30 month window plus 4 overlap months used to facilitate the rolloff during the update process) Note: See *Data Enhancement Functional Specifications for Eligibility, Populations, and DHS Core,* provided in this System Design under a separate tab, for more information on the Eligibility Table.

12.2 Provider Tagging

Tagging to the Provider Background Table is accomplished by attempting to match on various Provider fields, in a specified order, until successful. Once a match is achieved, further attempts are not made and specified fields are copied from the Provider record to the claim record.

The Claims Convert process tags to the Provider Background Table to retrieve Billing Provider information and upon a successful match, copies the following fields from the Provider record to the Claim record: PROVID, LATCODE, LONGCODE and PROVZIPB. If none of the attempted matches are successful, the F35-PROVIDER-NUMBER, with a hyphen inserted in front, is copied to the claim PROVID; the hyphen is added to easily identify that the attempted Provider tag was not successful. If the F35-PROVIDER-NUMBER contains all zeros, nines, spaces or is a null value, tagging is not attempted and spaces are moved to PROVID.

For non-dental claims (PGMCODE <> 0) attempts to match on the following criteria are made in sequential order:

- F35-PROVIDER-NUMBER equals Provider MCALID
- F35-PROVIDER-NUMBER equals Provider PROVLIC (collapsed version of license number)
- F35-PROVIDER-NUMBER equals Provider PROVLICU (un-collapsed version of license number)
- F35-PROVIDER-NUMBER equals Provider PROVTAX
- F35-PROVIDER-NUMBER is numeric and F35-PROVIDER-NUMBER equals the Provider PROVSSN
- Medi-Cal program code is Managed Care (PGMCODE = 2 or 4) and F35-PROVIDER-NUMBER equals Provider PROVPLAN

For dental claims (PGMCODE = 0) attempt to match on the following criteria:

- The F35-PROVIDER-NUMBER (positions 4-9) equals Provider PROVPLAN

For Mental Health claims (PGMCODE = 8) attempt to match on the following criteria:

- **The F35-PROVIDER-NUMBER (positions 4-9) equals Provider MCALID**

13. Summary of Document Changes

Date	Author	Phase	IRs	Description of Changes
3/15/00	**T. Poyner**	**5**	**1221**	**Updated the index section to reflect how the indexes changed in Phase 4 (documentation was not up-to-date).**
1/29/00	**L. Richardson**	**5**	**1530**	**In Section 8.1, added HDRPAID to the table of financial fields.**
1/29/00	**L. Richardson**	**5**	**1399**	**Removed the AMBPROC2 map as the finalized design did not require it.**
1/7/00	**L. Richardson**	**5**	**1411**	**Added Mental Health Provider Tag Logic**
11/1/99	T. Poyner	5		Changes made for Phase 5 Conditional Approval.
9/7/99	L. Richardson	5	965	Added RVU related maps that are used in the new RVU assignment logic
8/20/99	L. Richardson	5	1237	Replaced Attachment 1 with the New F35-File Layout
8/20/99	L. Richardson	5	1052	Added new field RESCNTY to tag from Elig.
8/20/99	L. Richardson	5	1247	Elig Tagging rules have changed so that we always tag these 'common' fields from Elig and never move from f35 (except BIRTHDT and SEX when the claim is for a NEWBORN) This is to improve analytic value of the MIS/DSS.
8/20/99	L. Richardson	5	1461	Create multiple maps for SVCTYP (map SVCCPT) to address the different lengths of PROC1
8/20/99	L. Richardson	5	1454	Changed the names of maps to match the mainframe version of the same maps for the fields DSTATUS, PLACE, SVCTYP
8/20/99	L. Richardson	5	1317	Added new map DNTLORIG to convert HCPCS to 3-Digit Denti-Cal codes

Date	Author	Phase	IRs	Description of Changes
4/12/99	L. Richardson	4	1210	Changed Date formats CCYYMMDD.
1/22/99	L. Richardson	4	739	Converted the document to the new format for functional specs, adding the following information and sections: 4-Inputs, 5-Outputs, 6-Reports, 7 Selection/Drop Criteria.
1/10/99	L. Richardson	4	739	Removed the Missing Rules and the Standard Conversion Rules as part of converting this document to the new standard for Functional Specs
1/8/99	K. Key	4	1162	Re-wrote and clarified the Provider Tagging section. Moved statement about Eligibility and Provider table creation precedents from the Tagging section to the Prerequisites section.
11/16/98	L. Richardson	3	1162	Indicated that the database window could be made more current than the original dates known during design; updated the eligibility tagging logic to address the use of the partitioned eligibility table; added PLANTYP as a field for the NETPROD map and added SVCTYP-LAWAIVER to the list of maps
6/9/98	L. Richardson	3	1001	Removed the sentence from the TAPEDT paragraph that indicated this field was MMDD format. The field is modified with IR 1001 to be the same date format as all other dates referenced in this document (CCYY-MM-DD)
6/8/98	J. Mulcahy	3		Revised the Pre-convert paragraph to now reference the Splitter document and the Record Selection section to reference the Drop Logic document.
12/31/97	W. Wallace			New Document.

Attachment 1. Input File Layout

The output of the Splitter program, which serves as the primary input to the Claims Convert, is listed below.

```
*  RFF035 ==> RF-F-035 FILE INCLUDE MEMBER.                *
    *-------------------------------------------------------------
    *  REV  07  07/21/99  LEVEL 08  PHIL TREINEN             *
    *    ADDED 5 TOOTH SURFACE FIELDS REDUCED FILLER AT END TO 5  *
    *    :PFX:-TOOTH-SURFACE-1 THRU -5  PIC X(01).           *
    *-------------------------------------------------------------
    *  REV  06  04/05/99  LEVEL 07  PHIL TREINEN             *
    *    :PFX:-ADMISSION-DATE         :PFX:-DISCHARGE-DATE     *
    *    :PFX:-CHECK-DATE             :PFX:-SURGERY-DATE       *
    *    :PFX:-HDR-FROM-DATE-OF-SERVICE :PFX:-ADJUDICATION-DATE   *
    *    :PFX:-HDR-TO-DATE-OF-SERVICE                         *
    *    :PFX:-DET-FROM-DATE-OF-SERVICE                       *
    *    :PFX:-DET-TO-DATE-OF-SERVICE                         *
    *   ALL CHANGED FROM S9(6) COMP-3 TO S9(8) COMP(8)        *
    *   FROM YYMMDD FORMAT TO CCYYMMDD FORMAT                 *
    *    :PFX:-BIRTHDATE CHANGED FROM PIC 9(7) TO PIC 9(8)     *
    *   FROM CYYMMDD FORMAT TO CCYYMMDD FORMAT                *
    *    :PFX:-FI-PROVIDER-TYPE       :PFX:-CATEGORY-OF-SERVICE *
    *     CHANGED FROM PIC X(2) TO X(3)                       *
    *  :PFX:-UNITS CHANGED FROM S9(5) COMP-3 TO S9(7)V9(3) COMP-3  *
    *-------------------------------------------------------------
    *  REV  05  01/09/96  LEVEL 06  KELLEY KLEMIN            *
    *    :PFX:-LABEL-TYPE IN DETAIL POSITION 37 HAS BEEN RENAMED  *
    *    TO :PFX:-EPSDT-SERVICE-IND EFFECTIVE FEBRUARY 1996 MOP.  *
    *-------------------------------------------------------------
    *  REV  04  05/24/95  LEVEL 05  KIM MAUN-PANNELL          *
    *    ADDED ANOTHER REDEFINES ON :PFX:-BIRTHDATE FOR THE MEDS  *
    *    AGE CHECK, WHICH REQUIRES A 1 OR 2 YEAR PLUS OR MINUS    *
    *    CHECK USING THE CENTURY AND THE YEARS.               *
    *-------------------------------------------------------------
    *  REV  03  08/22/94  LEVEL 04  KELLEY KLEMIN             *
    *    AS A RESULT OF SDN 4002 AND ENHANCEMENTS 17 & 18, WHICH  *
    *    WERE EFFECTIVE WITH THE NOVEMBER 1994 MONTH OF PAYMENT,  *
    *    ADDED TWO DATA ELEMENTS TO THE END OF THE HEADER:       *
```

```
*    :PFX:-CLAIM-FORM-INDICATOR AND :PFX:-ADMIT-SOURCE.      *
*    ALSO MADE SEVERAL OTHER CHANGES TO FACILITATE THE USE   *
*    OF SEVERAL FIELDS.                                      *
*-------------------------------------------------------------
*  REV  02  08/11/94  LEVEL 03  KIM MAUN-PANNELL             *
*    DATA ELEMENT :PFX:-PLAN-CODE GOT TWO NEW 88 LEVELS AND  *
*    LOST ONE.  THE OLD MIO 88 LEVEL WENT AWAY.  THE NEW ONES *
*    FOR PLAN CODES 1 AND 2 WERE ADDED.                      *
*-------------------------------------------------------------
*  REV  01  05/09/94  LEVEL 02  KELLEY KLEMIN                *
*    DATA ELEMENT :PFX:-MEDICARE-PAID-AMT-CAL WAS CHANGED TO  *
*    :PFX:-DET-OTHER-COVERAGE-AMOUNT PER MCSS REQUEST. THE   *
*    PICTURE DID NOT CHANGE, JUST THE DATA ELEMENT NAME.     *
*    THE OLD NAME WAS RETAINED AS A REDEFINES.  DIFFERENT    *
*    BREAKDOWNS OF THE PROVIDER NUMBER, DIAGNOSIS AND        *
*    ACCOMMODATION CODE WERE ADDED.                          *
*-------------------------------------------------------------
*  REV NEW  01/12/94  LEVEL 01  KELLEY KLEMIN                *
*    INCLUDE MEMBER CREATED FOR RF-F-035 FILE.  THIS INCLUDE  *
*    IS GOOD FOR 35 FILES CREATED ON OR AFTER MAR 1994 MONTH  *
*    OF PAYMENT, THE EFFECTIVE DATE OF ENHANCEMENTS 19 & 49   *
*    AND SDN 3048, WHICH CHANGED THE 35 FILE LAYOUT.         *
*-------------------------------------------------------------
* REVISED 2/20/98  THIS IS A FIXED LENGTH VERION OF THE STANDARD
* RF35 FILE LAYOUT.  THIS VERSION HAS 1 HEADER AND 1 DETAIL AND
* HAS THE VARYING REMOVED.  OTHERWISE IT IS AN EXACT DUPLICATE
* OF THE VARIABLE VERSION.
*****************************************************************
 01  :PFX:-PAID-CLAIM-RECORD.

    05  :PFX:-HEADER.
       10  :PFX:-RECORD-ID            PIC S9(03)  COMP-3.
       10  :PFX:-SEGMENT-CNT          PIC S9(04)  COMP.
          88  :PFX:-VALID-SEGMENT-CNT     VALUES +0 THRU +99.
       10  :PFX:-PLAN-CODE            PIC X(01).
          88  :PFX:-DELTA-PLAN-CODE       VALUE '0'.
          88  :PFX:-DDSW-PCSP-PLAN-CODE   VALUE '1'.
          88  :PFX:-GMC-PLAN-CODE         VALUE '2'.
          88  :PFX:-RHF-PLAN-CODE         VALUE '3'.
          88  :PFX:-HEALTH-INIT-PLAN-CODE VALUE '4'.
          88  :PFX:-EPSDT-PLAN-CODE       VALUE '5'.
          88  :PFX:-DDS-PLAN-CODE         VALUE '6'.
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    88  :PFX:-SD-MC-PLAN-CODE      VALUE '8'.
    88  :PFX:-EDS-PLAN-CODE        VALUE '9'.
    88  :PFX:-CSC-PLAN-CODE        VALUE '9'.
  10  :PFX:-PLAN-CODE-N REDEFINES
    :PFX:-PLAN-CODE           PIC 9(01).
  10  :PFX:-CLAIM-TYPE          PIC X(01).
    88  :PFX:-VALID-CLAIM-TYPE     VALUE '1' THRU '6'.
    88  :PFX:-OUTPATIENT-CLAIM     VALUE '1'.
    88  :PFX:-INPATIENT-CLAIM      VALUE '2'.
    88  :PFX:-DRUG-CLAIM           VALUE '3'.
    88  :PFX:-MEDICAL-CLAIM        VALUE '4'.
    88  :PFX:-DENTAL-CLAIM         VALUE '5'.
    88  :PFX:-MEDI-SCREEN-CLAIM    VALUE '6'.
  10  :PFX:-CLAIM-TYPE-N REDEFINES
    :PFX:-CLAIM-TYPE          PIC 9(01).
  10  :PFX:-ICN                 PIC S9(13)  COMP-3.
  10  :PFX:-BENE-ID.
    15  :PFX:-BID-COUNTY.
      20  :PFX:-BID-CNTY     PIC 9(02).
    15  :PFX:-BID-AID-CODE.
      20  :PFX:-BID-TENS-AID  PIC X(01).
      20  :PFX:-BID-UNITS-AID PIC X(01).
    15  :PFX:-BID-CASE-FBU-PERSON.
      20  :PFX:-BID-CASE-NUMBER PIC X(07).
      20  :PFX:-BID-FBU       PIC X(01).
      20  :PFX:-BID-PERSON-NUMBER
                    PIC X(02).
    15  FILLER  REDEFINES
      :PFX:-BID-CASE-FBU-PERSON.
      20  :PFX:-BID-OTHER-ID-IDENTIFIER
                    PIC X(01).
        88  :PFX:-BID-OTHER-ID-VALUES
                    VALUES '9' 'M' 'C'.
        88  :PFX:-BID-OTHER-ID-SSN
                    VALUE '9'.
        88  :PFX:-BID-OTHER-ID-MEDS-ID
                    VALUE 'M'.
        88  :PFX:-BID-OTHER-ID-CIN
                    VALUE 'C'.
      20  :PFX:-BID-OTHER-ID-OR-MEDS-ID
                    PIC X(09).
  10  :PFX:-BENE-NAME           PIC X(15).
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           10  :PFX:-BENE-SEX            PIC X(01).
             88  :PFX:-SEX-MALE           VALUE 'M' '1'.
             88  :PFX:-SEX-FEMALE         VALUE 'F' '2'.
             88  :PFX:-SEX-UNKNOWN        VALUE ' '.
           10  :PFX:-BENE-RACE           PIC X(01).
           10  :PFX:-BENE-HIC            PIC X(12).
           10  :PFX:-PROVIDER-ZIP-CODE.
             15  :PFX:-PROVIDER-ZIP-5    PIC X(05).
             15  :PFX:-PROVIDER-ZIP-4    PIC X(04).
           10  :PFX:-PROVIDER-NUMBER.
             15  :PFX:-PROVIDER-NUMBER-FIRST-3
                          PIC X(03).
             15  :PFX:-PROVIDER-NUMBER-LAST-6.
               20  :PFX:-PROVIDER-NUMBER-4-TO-7
                          PIC X(04).
               20  :PFX:-PROVIDER-NUMBER-8-TO-9
                          PIC X(02).
           10  :PFX:-REIMBURSEMENT-RATE    PIC 9(03).
           10  :PFX:-PATIENT-LIABILITY     PIC S9(7)V9(2)  COMP-3.
           10  :PFX:-PROVIDER-COUNTY.
             15  :PFX:-PROVIDER-CNTY     PIC 9(02).
           10  :PFX:-PROVIDER-SPECIALTY    PIC X(02).
           10  :PFX:-VENDOR-CODE.
             15  :PFX:-PROVIDER-TYPE     PIC X(02).
           10  :PFX:-VENDOR-CODE-N REDEFINES
             :PFX:-VENDOR-CODE          PIC 9(02).
             88  :PFX:-VALID-VENDOR-CODE     VALUES 01 THRU 99.
           10  FILLER                    PIC X(01).
           10  :PFX:-DISCHARGE-CODE       PIC X(01).
           10  :PFX:-OFFSET-INDICATOR      PIC X(01).
           10  :PFX:-SURGERY-CODE         PIC X(01).
             88  :PFX:-SURGERY            VALUE 'S'.
           10  :PFX:-MEDICARE-INDICATOR    PIC X(01).
             88  :PFX:-MEDICARE-IND-1       VALUE '1'.
           10  :PFX:-ADMISSION-DATE       PIC S9(8)   COMP-3.
      ***          DATE IS IN CCYYMMDD FORMAT.
           10  :PFX:-DISCHARGE-DATE       PIC S9(8)   COMP-3.
      ***          DATE IS IN CCYYMMDD FORMAT.
           10  :PFX:-CHECK-DATE           PIC S9(8)   COMP-3.
      ***          CHECK DATE IS THE MONTH OF PAYMENT (MOP).
      ***          DATE IS IN CCYYMMDD FORMAT.
           10  :PFX:-PRIMARY-DIAGNOSIS.
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           15  :PFX:-PRIMARY-DIAGNOSIS-1-4.
             20  :PFX:-PRIMARY-DIAGNOSIS-1-3.
               25  :PFX:-PRIMARY-DIAG-1
                           PIC X(01).
               25  :PFX:-PRIMARY-DIAG-2
                           PIC X(01).
               25  :PFX:-PRIMARY-DIAG-3
                           PIC X(01).
             20  :PFX:-PRIMARY-DIAG-4 PIC X(01).
           15  :PFX:-PRIMARY-DIAG-5    PIC X(01).
         10  :PFX:-CO-INSURANCE-AMOUNT   PIC S9(7)V9(2)  COMP-3.
         10  :PFX:-HDR-MEDI-CAL-AMOUNT-BILLED
                           PIC S9(7)V9(2)  COMP-3.
         10  :PFX:-HDR-MEDI-CAL-AMOUNT-PAID
                           PIC S9(7)V9(2)  COMP-3.
         10  :PFX:-FAMILY-PLANNING-CLAIM PIC X(01).
         10  :PFX:-FAMILY-PLANNING-SYSTEM PIC X(01).
         10  :PFX:-ADJUSTMENT-INDICATOR  PIC X(01).
           88  :PFX:-NEGATIVE-ADJUSTMENT   VALUES '2' '3' '5'.
         10  :PFX:-DAYS-STAY            PIC S9(3)   COMP-3.
           88  :PFX:-DAYS-STAY-1THRU60     VALUES +1 THRU +60.
         10  :PFX:-OTHER-COVERAGE-AMOUNT PIC S9(7)V9(2)  COMP-3.
         10  :PFX:-ADJUSTMENT-ICN        PIC S9(13)  COMP-3.
         10  :PFX:-HDR-FROM-DATE-OF-SERVICE
                           PIC S9(8)   COMP-3.
***            FROM DATE IS THE MONTH OF SERVICE (MOS).
***            DATE IS IN CCYYMMDD FORMAT.
         10  :PFX:-HDR-TO-DATE-OF-SERVICE PIC S9(8)  COMP-3.
***            DATE IS IN CCYYMMDD FORMAT.
         10  FILLER                  PIC X(04).
         10  :PFX:-OTHER-COVERAGE-INDICATOR
                           PIC X(01).
         10  :PFX:-SSN-OR-MEDS-ID.
           15  :PFX:-SSN-OR-MEDS-ID-1  PIC X(01).
             88  :PFX:-PSEUDO-MEDS-ID-START
                               VALUES '8' '9'.
           15  :PFX:-SSN-OR-MEDS-ID-2-8 PIC X(07).
           15  :PFX:-SSN-OR-MEDS-ID-9  PIC X(01).
             88  :PFX:-PSEUDO-MEDS-ID-END VALUE 'P'.
         10  :PFX:-BIRTHDATE.
           15  :PFX:-BIRTH-CENTURY-YEAR-MONTH.
             20  :PFX:-BIRTH-CENTURY PIC 9(02).
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           20  :PFX:-BIRTH-YEAR-MONTH.
              25  :PFX:-BIRTH-YEAR PIC 9(02).
              25  :PFX:-BIRTH-MONTH PIC 9(02).
           15  :PFX:-BIRTH-DAY        PIC 9(02).
        10  FILLER  REDEFINES
           :PFX:-BIRTHDATE.
           15  FILLER                 PIC X(02).
           15  :PFX:-BIRTHDATE-YYMMDD.
              20  :PFX:-BIRTHDATE-YY  PIC X(02).
              20  :PFX:-BIRTHDATE-MM  PIC X(02).
              20  :PFX:-BIRTHDATE-DD  PIC X(02).
        10  FILLER  REDEFINES
           :PFX:-BIRTHDATE.
           15  :PFX:-BIRTHDATE-YYY    PIC X(04).
           15  FILLER                 PIC X(04).
        10  FILLER                    PIC X(06).
        10  :PFX:-CCS                 PIC X(01).
        10  :PFX:-PROVIDER-NAME       PIC X(28).
        10  :PFX:-MINOR-CONSENT-SERVICE PIC X(02).
        10  :PFX:-RESTRICTED-SERVICE   PIC X(02).
        10  :PFX:-FI-CLAIM-TYPE       PIC X(02).
        10  :PFX:-PHP-CODE            PIC X(03).
        10  :PFX:-FI-PROVIDER-TYPE     PIC X(03).
        10  :PFX:-CATEGORY-OF-SERVICE  PIC X(03).
        10  :PFX:-SECONDARY-DIAGNOSIS.
           15  :PFX:-SECONDARY-DIAGNOSIS-1-4.
              20  :PFX:-SECONDARY-DIAGNOSIS-1-3.
                 25  :PFX:-SECONDARY-DIAG-1
                           PIC X(01).
                 25  :PFX:-SECONDARY-DIAG-2
                           PIC X(01).
                 25  :PFX:-SECONDARY-DIAG-3
                           PIC X(01).
              20  :PFX:-SECONDARY-DIAG-4
                           PIC X(01).
           15  :PFX:-SECONDARY-DIAG-5  PIC X(01).
        10  :PFX:-EMERGENCY-IND       PIC X(01).
           88  :PFX:-EMERGENCY-CLAIM      VALUE 'Y'.
        10  :PFX:-ADJUDICATION-DATE    PIC S9(8)   COMP-3.
***           DATE IS IN CCYYMMDD FORMAT.
        10  :PFX:-ADMIT-TYPE          PIC X(01).
        10  :PFX:-PATIENT-STATUS       PIC X(02).
```

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        10  :PFX:-PRIMARY-SURGERY-CODE  PIC X(05).
        10  :PFX:-SECONDARY-SURGERY-CODE PIC X(05).
        10  :PFX:-SURGERY-DATE         PIC S9(8)   COMP-3.
***             DATE IS IN CCYYMMDD FORMAT.
        10  :PFX:-LTC-SOC-IND          PIC X(01).
          88  :PFX:-LTC-SOC              VALUE 'Y'.
        10  :PFX:-CLAIM-FORM-INDICATOR  PIC X(01).
          88  :PFX:-CLAIM-FORM-UB-92     VALUE 'U'.
        10  :PFX:-ADMIT-SOURCE         PIC X(01).
          88  :PFX:-ADMIT-TRANSFER       VALUES '4' '5' '6'.
          88  :PFX:-ADMIT-EMERGENCY-TRANSFER
                                VALUE '4'.
          88  :PFX:-ADMIT-ELECTIVE-TRANSFER VALUE '5'.
          88  :PFX:-ADMIT-DELIVERY-TRANSFER VALUE '6'.
        10  :PFX:-CIN                  PIC X(09).
        10  FILLER                     PIC X(19).

      05  :PFX:-CLAIM-DETAILS.
        10  :PFX:-DETAIL-SEGMENT.
          15  :PFX:-DET-MEDI-CAL-AMOUNT-BILLED
                                PIC S9(7)V9(2)  COMP-3.
          15  :PFX:-DET-MEDI-CAL-AMOUNT-PAID
                                PIC S9(7)V9(2)  COMP-3.
          15  :PFX:-MEDICARE-AMOUNT-BILLED
                                PIC S9(7)V9(2)  COMP-3.
          15  :PFX:-MEDICARE-AMOUNT-PAID
                                PIC S9(7)V9(2)  COMP-3.
          15  :PFX:-DEDUCTION-CODE    PIC X(01).
          15  :PFX:-DEDUCTION-AMOUNT  PIC S9(7)V9(2)  COMP-3.
          15  :PFX:-DET-FROM-DATE-OF-SERVICE
                                PIC S9(8)       COMP-3.
***               DATE IS IN CCYYMMDD FORMAT.
          15  :PFX:-DET-TO-DATE-OF-SERVICE
                                PIC S9(8)   COMP-3.
***               DATE IS IN CCYYMMDD FORMAT.
          15  :PFX:-PCCM-IND          PIC X(01).
          15  :PFX:-OHC-CODE          PIC X(01).
          15  :PFX:-EPSDT-SERVICE-IND PIC X(01).
          15  :PFX:-TAR               PIC X(01).
          15  :PFX:-MIO-POS           PIC X(01).
          15  :PFX:-TOS               PIC X(01).
          15  :PFX:-PROCEDURE-AREA.
```

```
    20  :PFX:-PROC-CODE-PREFIX
                    PIC X(06).
    20  :PFX:-PROCEDURE-CODE.
      25  :PFX:-PROC-CODE-FIRST-4
                    PIC X(04).
      25  :PFX:-PROC-CODE-LAST-1
                    PIC X(01).
  15  :PFX:-NDC-UPC-HRI-CODE REDEFINES
    :PFX:-PROCEDURE-AREA.
    20  :PFX:-NDC-UPC-HRI-LABELER
                    PIC X(05).
    20  :PFX:-NDC-UPC-HRI-PRODUCT
                    PIC X(04).
    20  :PFX:-NDC-UPC-HRI-PACKAGE
                    PIC X(02).
  15  FILLER  REDEFINES
    :PFX:-PROCEDURE-AREA.
    20  :PFX:-MEDI-CAL-CODE-PREFIX
                    PIC X(04).
      88  :PFX:-MEDI-CAL-DRUG VALUE LOW-VALUES.
    20  :PFX:-MEDI-CAL-DRUG-AREA.
      25  :PFX:-MEDI-CAL-DRUG-CODE.
        30  :PFX:-MEDI-CAL-DRUG-CD
                    PIC X(04).
        30  :PFX:-MEDI-CAL-DRUG-STR
                    PIC X(01).
      25  :PFX:-MEDI-CAL-DRUG-MFG
                    PIC X(02).
  15  :PFX:-PROCEDURE-INDICATOR PIC X(01).
  15  :PFX:-ACCOMMODATION-CODE.
    20  :PFX:-ACCOM-CODE.
      25  :PFX:-ACCOM-1   PIC X(01).
      25  :PFX:-ACCOM-2   PIC X(01).
    20  :PFX:-ACCOM-H      PIC X(01).
  15  :PFX:-TOOTH-OR-MODIFIER PIC X(02).
  15  :PFX:-UNITS          PIC S9(7)V9(3) COMP-3.
  15  :PFX:-PRESCRIPTION-NUMBER.
    20  :PFX:-PRESCRIPTION-FIRST-2
                    PIC X(02).
    20  :PFX:-PRESCRIPTION-LAST-6
                    PIC X(06).
  15  FILLER  REDEFINES
```

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   :PFX:-PRESCRIPTION-NUMBER.
   20  :PFX:-PRESCRIPTION-FIRST-6
                  PIC X(06).
   20  :PFX:-PRESCRIPTION-LAST-2
                  PIC X(02).
15  :PFX:-COPAY-AMOUNT     PIC S9(3)V99    COMP-3.
15  :PFX:-PRICE-RESTRICTION PIC X(01).
15  :PFX:-PRESC-REF-PROV-NUM PIC X(09).
15  :PFX:-EPSDT-REFERR-CDS  PIC X(02).
15  :PFX:-COPAY-IND        PIC X(01).
15  :PFX:-DRUG-MANUFACTURER PIC X(02).
15  :PFX:-FI-TOS           PIC X(01).
15  :PFX:-MEDI-CAL-REIM-AMT PIC S9(7)V9(2)  COMP-3.
15  :PFX:-DET-OTHER-COVERAGE-AMOUNT
                  PIC S9(7)V9(2)  COMP-3.
15  :PFX:-MEDICARE-PAID-AMT-CALC REDEFINES
   :PFX:-DET-OTHER-COVERAGE-AMOUNT
                  PIC S9(7)V9(2)  COMP-3.
15  :PFX:-ORIG-POS-2.
   20  :PFX:-ORIG-POS-1    PIC X(01).
   20  :PFX:-POS-1-FILLER  PIC X(01).
15  :PFX:-SMART-KEY.
   20  :PFX:-SMART-KEY-GTC PIC X(02).
   20  :PFX:-SMART-KEY-STC PIC X(04).
   20  :PFX:-SMART-KEY-HICL PIC X(05).
   20  :PFX:-SMART-KEY-STR PIC X(04).
   20  :PFX:-SMART-KEY-DOSE PIC X(03).
   20  :PFX:-SMART-KEY-RT  PIC X(02).
   20  :PFX:-SMART-KEY-PS  PIC X(03).
   20  :PFX:-SMART-KEY-UDUU PIC X(01).
15  :PFX:-DAYS-SUPPLY      PIC S9(3)   COMP-3.
15  :PFX:-MEDICAL-SUPPLY-IND PIC X(01).
   88  :PFX:-MEDICAL-SUPPLY    VALUE 'Y'.
15  :PFX:-COMPOUND-DRUG-IND PIC X(01).
   88  :PFX:-COMPOUND-DRUG     VALUE 'Y'.
15  :PFX:-TOOTH-SURFACE-1   PIC X(01).
15  :PFX:-TOOTH-SURFACE-2   PIC X(01).
15  :PFX:-TOOTH-SURFACE-3   PIC X(01).
15  :PFX:-TOOTH-SURFACE-4   PIC X(01).
15  :PFX:-TOOTH-SURFACE-5   PIC X(01).
15  FILLER               PIC X(05).
```

Attachment 2. Report Samples

Attachment 3. Field Level Details

Attachment 3 (on the pages that follow) includes the field level details for the fields on the DataScan Core Medical Service Tables (Inpatient, Inpatient Paid, Outpatient, and Outpatient Paid).